

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Do not, coroner, etc. must be casually related. Coroner cannot certify to a death due to natural causes. All diseases in Part I must be casually related.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4229

FILED FEB 28 1957

STATE FILE NUMBER  
109 Primary Registration District No. 4180 Registrar's No. 131

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dunklin</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Campbell</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Clarxton</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SB Rest Home</u>		Length of stay in lb <u>3 wks</u>	d. STREET ADDRESS (If outside, give location) <u>-</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Martha Ann Reeves</u>			4. DATE OF DEATH <u>Feb - 7 - 1957</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1868-5-20</u>	9. AGE (In years last birthday) <u>88-8-17</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Dunklin County, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		17. INFORMANT <u>Alma Jones-Libbourn Mo RI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>2</u>		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <u>2/7/57</u> to _____ and last saw her <del>him</del> alive on <u>2/7/57</u> Death occurred at <u>9:30a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Wallace A. Belsky M.D.</u>			22b. ADDRESS <u>Campbell Mo.</u>		22c. DATE SIGNED <u>2/14/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-9-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Hilliard Cemetery</u>		23d. LOCATION (City, town, or county) <u>Clarxton</u>	(State) <u>Mo</u>
24. FUNERAL DIRECTOR <u>T. P. Knight</u>		ADDRESS <u>Malden Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2/18/57</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Beulah Samples</u>	

RECEIVED DUNKLIN COUNTY HEALTH

DEPARTMENT 2-27-57

COUNTY FILE NUMBER 257-5

MAR 5 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was examined by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student..... Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license). If embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.